New Jersey Department of Health and Senior Services
Division of Aging and Community Services
Office of Long Term Care Options

HOSPITAL PREADMISSION SCREENING REFERRAL*

PLEASE PRINT

Hospital _____ Date _____

Referred By _____

Telephone Number _____

PATIENT INFORMATION

Name _____ DOB _____
(Last) *(First)* *(MI)*

Sex ☐ Male ☐ Female

HSP # _____ SS# _____

Home Address _____

_____

Responsible Party _____

Home Telephone No. ( ) _____ Work Telephone No. ( ) _____

ADMISSION INFORMATION

Date of Admission _____ Floor _____

Admitted From _____ Room # _____

Primary Admitting Diagnosis _____

Secondary Admitting Diagnosis _____

Date Referred to D/C Planner/Soc. Serv. _____

Date Pt. Met At-Risk Criteria _____

ELIGIBILITY STATUS

☐ Currently Medicaid Eligible Date Referred to CWA _____

☐ Application in Process

☐ 180 Days Potentially Eligible

***Form may be used to FAX information or as written confirmation of telephone referral to LTCFO.**